V0301 MASTOIDECTOMY - ILLOGICAL FOR USE WITH DIAGNOSIS OF BREAST CANCERS

Guideline: Certain procedures are performed only when a specific diagnosis is present. It is illogical to report mastoidectomy for breast cancer cases. Index coding can easily cause this combination to occur. The presence of the procedure codes (20.4x) without a related diagnosis code would clearly be in error.

V0301 Exclusive check (if match, error) - P001

Procedure Table 3001	20.41	Simple mastoidectomy
	20.42	Radical mastoidectomy
	20.49	Other mastoidectomy
Relational Table 3003	174.0	Malignant neoplasm, nipple and areola, female
	174.1	Malignant neoplasm, central portion, female
	174.2	Malignant neoplasm, upper-inner quadrant, female
	174.3	Malignant neoplasm, lower-inner quadrant, female
	174.4	Malignant neoplasm, upper-outer quadrant, female
	174.5	Malignant neoplasm, lower-outer quadrant, female
	174.6	Malignant neoplasm, axillary tail, female
	174.8	Malignant neoplasm, other specified sites, female breast
	174.9	Malignant neoplasm, breast (female), unspecified
	175.0	Malignant neoplasm, nipple and areola, male
	175.9	Malignant neoplasm, other and unspecified sites, male breast

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References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 57; 1991, page 61.

~~V0302 BONE MARROW TRANSPLANT - ILLOGICAL TO USE WITH DIAGNOSIS OF BONE MARROW DONOR V59.3~~ - *effective change as of 8/1/97*

Guideline: Certain procedures are performed only when a specific diagnosis is present. It is illogical to report bone marrow transplant procedure codes with diagnosis code of bone marrow donor. A live donor is a person admitted to the hospital for the sole purpose of donating an organ, and is coded to category V59. Harvesting or aspiration or donation of bone marrow for bone marrow transplantation is coded 41.91.

V0302 Exclusive check (if match, error) - P002

Procedure Table 3001	41.00	Bone marrow transplant
	41.01	Autologous bone marrow transplant
	41.02	Allogeneic bone marrow transplant with purging
	41.03	Allogeneic bone marrow transplant without purging
	41.04	Autologous hematopoietic stem cell transplant
Relational Table 3003	V59.3	Bone marrow donor

References: Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1984, page 8; Jan/Feb 1985, page 15; 1st Quarter 1991, pages 3-6.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 57; 1991, page 61.

Steps to Coding with ICD-9-CM, Module II-The Advanced Coder, 1991, page 41

New Change: Coding Clinic for ICD-9-CM, AHA, 4th Quarter 1995, page 62; 3rd Quarter 1997, page 16.

V0303 INCIDENTAL APPENDECTOMY PERFORMED FOR APPENDICEAL PATHOLOGY

Guideline: The code for incidental appendectomy (47.1) is used when the appendix is removed as a routine prophylactic removal in the course of other abdominal surgery.

The procedure code 47.1 should not be assigned when there is a diagnosis of significant appendiceal pathology. However, it should be assigned when the appendix was removed as an incidental procedure and the pathology report indicates minor findings such as fecalith or mucocele.

V0303 Exclusive check (if match, error) - P003

Procedure Table 3001	47.1	Incidental appendectomy *(before 10/1/96)*
	47.11	Laparoscopic incidental appendectomy *(after 10/1/96)*
	47.19	Other incidental appendectomy *(after 10/1/96)*
Relational Table 3003	540.0	Acute appendicitis with generalized peritonitis
	540.1	Acute appendicitis with peritoneal abscess
	540.9	Acute appendicitis, without mention of peritonitis
	541	Appendicitis, unqualified
	542	Other appendicitis

References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 139; 1991, page 167; 1994, page 175.

Coding Clinic for ICD-9-CM, AHA, 2nd Quarter 1990, page 26.

V0304	**TRACHEOSTOMY REVISION**	**- STATUS versus ATTENTION**
V0305	**GASTROSTOMY REVISION**	**- STATUS versus ATTENTION**
V0306	**INTESTINAL STOMA REVISION**	**- STATUS versus ATTENTION**
V0307	**ILEOSTOMY REVISION**	**- STATUS versus ATTENTION**
V0308	**COLOSTOMY REVISION**	**- STATUS versus ATTENTION**
V0309	**CYSTOSTOMY REVISION**	**- STATUS versus ATTENTION**
V0310	**URINARY REVSION**	**- STATUS versus ATTENTION**

Guideline: Certain procedures are performed only when a specific diagnosis is present. It is illogical to report diagnosis of status ostomy in admission for the ostomy closure.

Codes from category V44 classify certain status without care that may influence the patient's health status, such as the presence of colostomy (V44.3).

Codes from category V55 are used to indicate that the purpose for administering care is to consolidate treatment or to deal with a residual state.

The codes for aftercare management are ordinarily used for planned care, such as attention to colostomy (V55.3).

Read the excludes notes under categories V44 and V55.

V0304 Exclusive check (if match, error) - P004

Procedure Table 3001	31.72	Closure of external fistula of trachea
	31.74	Revision of tracheostomy
Relational Table 3003	V44.0	Tracheostomy status

V0304 *HINT: Attention to tracheostomy V55.0 should be the principal diagnosis.*

V0305 Exclusive check (if match, error) - P005

Procedure Table 3001	44.62	Closure of gastrostomy
Relational Table 3003	V44.1	Gastrostomy status

V0305 *HINT: Attention to gastrostomy V55.1 should be the principal diagnosis.*

V0304 TRACHEOSTOMY REVISION - STATUS versus ATTENTION
V0305 GASTROSTOMY REVISION - STATUS versus ATTENTION
V0306 INTESTINAL STOMA REVISION - STATUS versus ATTENTION
V0307 ILEOSTOMY REVISION - STATUS versus ATTENTION
V0308 COLOSTOMY REVISION - STATUS versus ATTENTION
V0309 CYSTOSTOMY REVISION - STATUS versus ATTENTION
V0310 URINARY REVSION - STATUS versus ATTENTION
CONTINUED (see guideline on page 412)

V0306 Exclusive check (if match, error) - P006

Procedure Table 3001	46.40	Revision of intestinal stoma, NOS
	46.50	Closure of intestinal stoma
Relational Table 3003	V44.2	Ileostomy status
	V44.3	Colostomy status
	V44.4	Other artificial opening of gastrointestinal tract

V0306 *HINT: One of the codes for attention to artificial opening in the intestine V55.2-V55.4 should be the principal diagnosis.*

V0307 Exclusive check (if match, error) - P007

Procedure Table 3001	45.31	Other local excision of lesion of duodenum (excision of redundant mucosa of duodenostomy)
	45.33	Local excision of lesion or tissue of small intestine, except duodenum (excision of redundant mucosa of ileostomy or jejunostomy)
	46.41	Revision of stoma of small intestine
	46.51	Closure of stoma of small intestine
Relational Table 3003	V44.2	Ileostomy status
	V44.4	Other artificial opening of gastrointestinal tract

V0307 *HINT: One of the codes for attention to small intestinal stoma V55.2 or V55.4 should be the principal diagnosis.*

V0304 TRACHEOSTOMY REVISION - STATUS versus ATTENTION
V0305 GASTROSTOMY REVISION - STATUS versus ATTENTION
V0306 INTESTINAL STOMA REVISION - STATUS versus ATTENTION
V0307 ILEOSTOMY REVISION - STATUS versus ATTENTION
V0308 COLOSTOMY REVISION - STATUS versus ATTENTION
V0309 CYSTOSTOMY REVISION - STATUS versus ATTENTION
V0310 URINARY REVSION - STATUS versus ATTENTION
CONTINUED (see guideline on page 412)

V0308 Exclusive check (if match, error) - P008

Procedure Table 3001	45.41	Excision of lesion or tissue of large intestine (excision of redundant mucosa of colostomy)
	46.43	Other revision of stoma of large intestine
	46.52	Closure of stoma of large intestine
Relational Table 3003	V44.3	Colostomy status

V0308 *HINT: Attention to colostomy V55.3 should be the principal diagnosis.*

V0309 Exclusive check (if match, error) - P009

Procedure Table 3001	57.22	Revision or closure of vesicostomy
	57.82	Closure of cystostomy
Relational Table 3003	V44.5x	Cystostomy status

V0309 *HINT: Attention to cystostomy V55.5 should be the principal diagnosis.*

V0304 **TRACHEOSTOMY REVISION** **- STATUS versus ATTENTION**
V0305 **GASTROSTOMY REVISION** **- STATUS versus ATTENTION**
V0306 **INTESTINAL STOMA REVISION** **- STATUS versus ATTENTION**
V0307 **ILEOSTOMY REVISION** **- STATUS versus ATTENTION**
V0308 **COLOSTOMY REVISION** **- STATUS versus ATTENTION**
V0309 **CYSTOSTOMY REVISION** **- STATUS versus ATTENTION**
V0310 **URINARY REVSION** **- STATUS versus ATTENTION**
CONTINUED (see guideline on page 412)

V0310 Exclusive check (if match, error) - P010

Procedure Table 3001	55.82	Closure of nephrostomy and pyelostomy
	55.89	Correction of ureteropelvic junction (revision of nephrostomy)
	56.62	Revision of other cutaneous ureterostomy
	56.83	Closure of ureterostomy
	58.42	Closure of urethrostomy
	58.49	Other repair of urethra (revision of urethrostomy)
Relational Table 3003	V44.6	Other artificial opening of urinary tract status

V0310 *HINT: Attention to artificial opening of urinary tract (nephrostomy, ureterostomy, urethrostomy) V55.6 should be the principal diagnosis.*

References: ICD-9-CM Codebook, Tabular Section, Categories V44 and V55, read the Excludes notes.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, pages 65-66 and 57; 1991, pages 72-73 and 61.

Steps to Coding with ICD-9-CM, Module II-The Advanced Coder, 1991, pages 38 and 40.

V0311 HERNIA REPAIRS - BILATERAL versus UNILATERAL

Guideline: When coding hernia repair, the coder should avoid using a bilateral repair code when the hernia itself is described as unilateral. A unilateral repair may be done even though bilateral hernias are present, but it is impossible to repair bilateral hernias when only one hernia exists.

V0311 Exclusive check (if match, error) - P011

Procedure Table 3001	53.10	Bilateral repair of inguinal hernia, NOS
	53.11	Bilateral repair of direct inguinal hernia
	53.12	Bilateral repair of indirect inguinal hernia
	53.13	Bilateral repair of inguinal hernia, one direct and one indirect
	53.14	Bilateral repair of direct inguinal hernia with graft or prosthesis
	53.15	Bilateral repair of indirect inguinal hernia with graft or prosthesis
	53.16	Bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis
	53.17	Bilateral inguinal hernia repair with graft or prosthesis, NOS
Relational Table 3003	550.00	Unilateral or unspecified inguinal hernia, with gangrene
	550.01	Unilateral or unspecified inguinal hernia, with gangrene, recurrent
	550.10	Unilateral or unspecified inguinal hernia, with obstruction
	550.11	Unilateral or unspecified inguinal hernia, with obstruction, recurrent
	550.90	Unilateral or unspecified inguinal hernia
	550.91	Unilateral or unspecified inguinal hernia, recurrent

V0311 Exclusive check (if match, error) - P012

Procedure Table 3001	53.31	Bilateral repair of femoral hernia with graft or prosthesis
	53.39	Other bilateral femoral herniorrhaphy
Relational Table 3003	551.00	Unilateral or unspecified femoral hernia with gangrene
	551.01	Unilateral or unspecified femoral hernia, recurrent
	552.00	Unilateral or unspecified femoral hernia with obstruction
	552.01	Unilateral or unspecified femoral hernia, recurrent
	553.00	Unilateral or unspecified femoral hernia
	553.01	Unilateral or unspecified femoral hernia, recurrent

References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 140; 1991, page 165.

Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1985, page 12.

V0312 HERNIA REPAIR WITHOUT DIAGNOSIS OF HERNIA

Guideline: Hernias are classified by type and site. Certain procedures are performed only when a specific diagnosis is present. It is illogical to report incisional/ventral hernia repair without a diagnosis of incisional/ventral hernia. It is also illogical to report umbilical hernia repair without a diagnosis of umbilical hernia.

V0312 Inclusive check (if no match, error) - I001

Procedure Table 3001	53.51	Incisional hernia repair
	53.61	Incisional hernia repair with prosthesis
Relational Table 3003	551.21	Incisional hernia with gangrene
	552.21	Incisional hernia with obstruction
	553.21	Incisional hernia

V0312 Inclusive check (if no match, error) - I002

Procedure Table 3001	53.59	Repair of other hernia of anterior abdominal wall
	53.69	Repair of other hernia of anterior abdominal wall with prosthesis
Relational Table 3003	551.20	Ventral hernia with gangrene
	551.29	Other ventral hernia (such as epigastric) with gangrene
	552.20	Ventral hernia with obstruction
	552.29	Other ventral hernia (such as epigastric) with obstruction
	553.20	Ventral hernia
	553.29	Other ventral hernia (such as epigastric or Spigelian)

V0312 Inclusive check (if no match, error) - I003

Procedure Table 3001	53.41	Repair of umbilical hernia with prosthesis
	53.49	Repair of umbilical hernia
Relational Table 3003	551.1	Umbilical hernia with gangrene
	552.1	Umbilical hernia with obstruction
	553.1	Umbilical hernia
	756.7	Anomalies of abdominal wall (omphalocele)

References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 140; 1991, page 165.

Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1985, page 12.

V0313 LEGAL ABORTION PROCEDURE WITH LEGALLY INCOMPLETE ABORTION DIAGNOSIS?

V0314 D&C FOLLOWING ABORTION PERFORMED FOR A COMPLETE ABORTION DIAGNOSIS?

Guideline: An abortion is considered to be incomplete as long as any placenta or other secundines remains. When an abortion procedure is performed to terminate a pregnancy, usually all products of conception are carefully removed and it is rare if there are still some products of conception left after surgery. The pathology report is a reliable source of information for identifying the state of an abortion procedure.

V0313 If all products of conception were removed for legal abortions, the fifth digit for abortion diagnosis should be "2" for "complete".

V0314 If some products of conception passed prior to surgery or some still remain after surgery (rare), the fifth digit for abortion diagnosis should be "1" for "incomplete".

V0313 Exclusive check (if match, error) - P013

Procedure Table 3001	69.01	Dilation and curettage for termination of pregnancy
	69.51	Aspiration curettage for termination of pregnancy
Relational Table 3003	635.00	Legally induced abortion complicated by genital tract and pelvic infection, unspecified
	635.01	Legally induced abortion complicated by genital tract and pelvic infection, incomplete
	635.10	Legally induced abortion complicated by delayed or excessive hemorrhage, unspecified
	635.11	Legally induced abortion complicated by delayed or excessive hemorrhage, incomplete
	635.20	Legally induced abortion complicated by damage to pelvic organs or tissues, unspecified
	635.21	Legally induced abortion complicated by damage to pelvic organs or tissues, incomplete
	635.30	Legally induced abortion complicated by renal failure, unspecified
	635.31	Legally induced abortion complicated by renal failure, incomplete
	635.40	Legally induced abortion complicated by metabolic disorder, unspecified
	635.41	Legally induced abortion complicated by metabolic disorder, incomplete

V0313 **LEGAL ABORTION PROCEDURE WITH LEGALLY INCOMPLETE ABORTION DIAGNOSIS?** - CONTINUED

V0314 **D&C FOLLOWING ABORTION PERFORMED FOR A COMPLETE ABORTION DIAGNOSIS?** - CONTINUED
(see guideline on page 418)

V0313 Exclusive check (if match, error) - P013 - CONTINUED

Relational Table 3003	635.50	Legally induced abortion complicated by shock, unspecified
	635.51	Legally induced abortion complicated by shock, incomplete
	635.60	Legally induced abortion complicated by embolism, unspecified
	635.61	Legally induced abortion complicated by embolism, incomplete
	635.70	Legally induced abortion complicated with other specified complications, unspecified
	635.71	Legally induced abortion complicated with other specified complications, incomplete
	635.80	Legally induced abortion with unspecified complication, unspecified
	635.81	Legally induced abortion with unspecified complication, incomplete
	635.90	Legally induced abortion without mention of complication, unspecified
	635.91	Legally induced abortion without mention of complication, incomplete

V0313 *HINT: If one of the procedures was performed to terminate the pregnancy, usually all the products are carefully removed, the fifth digit for legally induced abortion diagnosis should be "2" complete.*

V0313 **LEGAL ABORTION PROCEDURE WITH LEGALLY INCOMPLETE ABORTION DIAGNOSIS?** - CONTINUED

V0314 **D&C FOLLOWING ABORTION PERFORMED FOR A COMPLETE ABORTION DIAGNOSIS?** - CONTINUED
(see guideline on page 418)

V0314 Exclusive check (if match, error) - P014

Procedure Table 3001	69.02	Dilation and curettage following delivery or abortion
	69.52	Aspiration curettage following delivery or abortion
Relational Table 3003	635.02	Legally induced abortion complicated by genital tract and pelvic infection, complete
	635.12	Legally induced abortion complicated by delayed or excessive hemorrhage, complete
	635.22	Legally induced abortion complicated by damage to pelvic organs or tissues, complete
	635.32	Legally induced abortion complicated by renal failure, complete
	635.42	Legally induced abortion complicated by metabolic disorder, complete
	635.52	Legally induced abortion complicated by shock, complete
	635.62	Legally induced abortion complicated by embolism, complete
	635.72	Legally induced abortion complicated with other specified complications, complete
	635.82	Legally induced abortion with unspecified complication, complete
	635.92	Legally induced abortion without mention of complication, complete

V0314 *HINT: If some products of conception passed prior to surgery or some still remain after surgery (rare), the fifth digit for abortion diagnosis should be "1" for incomplete. If the products of conception passed prior to surgery, the diagnosis should be spontaneous abortion instead of legally induced abortion.*

References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 194; 1991, page 224.

Steps to Coding with ICD-9-CM, Module II-The Advanced Coder, CHIA, 1991, pages 162-165.

Journal of CHIA, "Is That All There Is?", January 1993, pages 22-23.

V0315 REPAIRS OF OBSTETRICAL LACERATIONS WITHOUT DIAGNOSIS OF OBSTETRICAL LACERATIONS

Guideline: Spontaneous episiotomy extensions and other perineal lacerations occurring during the birth of a baby are assigned codes from category 664, Trauma to perineum and vulva during delivery. It is illogical to report repairs of spontaneous episiotomy extensions or lacerations without the appropriate code from category 664, Trauma to perineum and vulva during delivery.

With the birth of the baby, the episiotomy can extend spontaneously; it is then considered to be a laceration. If the physician performs an episiotomy and it itself extends spontaneously (now considered a laceration) and needs repair, both procedures 73.6 episiotomy and 75.6x repair of other current obstetric laceration can be reported. However, if the physician extends the episiotomy, it is not considered a laceration and only the episiotomy code should be assigned.

V0315 Inclusive check (if no match, error) - I004

Procedure Table 3001	75.61	Repair of current obstetric laceration of bladder and urethra
	75.62	Repair of current obstetric laceration of rectum and sphincter ani
	75.69	Repair of other current obstetric laceration
Relational Table 3003	664.00	1st degree perineal laceration, unspecified episode
	664.01	1st degree perineal laceration, delivered with antepartum condition
	664.04	1st degree perineal laceration, postpartum condition
	664.10	2nd degree perineal laceration, unspecified episode
	664.11	2nd degree perineal laceration, delivered with antepartum condition
	664.14	2nd degree perineal laceration, postpartum condition
	664.20	3rd degree perineal laceration, unspecified episode
	664.21	3rd degree perineal laceration, delivered with antepartum condition
	664.24	3rd degree perineal laceration, postpartum condition
	664.30	4th degree perineal laceration, unspecified episode
	664.31	4th degree perineal laceration, delivered with antepartum condition
	664.34	4th degree perineal laceration, postpartum condition
	664.40	Unspecified perineal laceration, unspecified episode
	664.41	Unspecified perineal laceration, delivered with antepartum condition
	664.44	Unspecified perineal laceration, postpartum condition

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V0315 **REPAIRS OF OBSTETRICAL LACERATIONS WITHOUT DIAGNOSIS OF OBSTETRICAL LACERATIONS** - CONTINUED
(see guideline on page 421)

V0315 Inclusive check (if no match, error) - I004 - Continued

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Relational Table 3003	664.50	Vulval and perineal hematoma, unspecified episode
	664.51	Vulval and perineal hematoma, delivered with antepartum condition
	664.54	Vulval and perineal hematoma, postpartum condition
	664.80	Other specified trauma to perineum and vulva, unspecified episode
	664.81	Other specified trauma to perineum and vulva, delivered with antepartum condition
	664.84	Other specified trauma to perineum and vulva, postpartum condition
	664.90	Unspecified trauma to perineum and vulva, unspecified episode
	664.91	Unspecified trauma to perineum and vulva, delivered with antepartum condition
	664.94	Unspecified trauma to perineum and vulva, postpartum condition
	665.30	Laceration of cervix, unspecified episode
	665.31	Laceration of cervix, delivered with antepartum condition
	665.34	Laceration of cervix, postpartum condition
	665.40	High vaginal laceration, unspecified episode
	665.41	High vaginal laceration, delivered with antepartum condition
	665.44	High vaginal laceration, postpartum condition
	665.50	Other injury to pelvic organs, unspecified episode
	665.51	Other injury to pelvic organs, delivered with antepartum condition
	665.54	Other injury to pelvic organs, postpartum condition
	665.70	Pelvic hematoma, unspecified episode
	665.71	Pelvic hematoma, delivered with antepartum condition
	665.72	Pelvic hematoma, delivered with postpartum condition
	665.74	Pelvic hematoma, postpartum condition
	674.20	Disruption of perineal wound, unspecified episode
	674.22	Disruption of perineal wound, delivered with antepartum condition
	674.24	Disruption of perineal wound, delivered with postpartum condition

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V0315 **REPAIRS OF OBSTETRICAL LACERATIONS WITHOUT DIAGNOSIS OF OBSTETRICAL LACERATIONS** - CONTINUED
(see guideline on page 421)

V0315 Inclusive check (if no match, error) - I004 - Continued

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Relational Table 3003	674.30	Other complications of obstetrical surgical wounds, unspecified episode
	674.32	Other complications of obstetrical surgical wounds, delivered with antepartum condition
	674.34	Other complications of obstetrical surgical wounds, delivered with postpartum condition

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References: Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1984, page 10; 1st Quarter 1992, pages 10-11.

Central Office on ICD-9-CM, Response to OSHPD's letter #1356.992 dated 11-2-92.

V0316 MASTECTOMY - ILLOGICAL FOR USE WITH DIAGNOSIS OF MASTOIDITIS AND MIDDLE EAR INFECTIONS

Guideline: Certain procedures are performed only when a specific diagnosis is present. It is illogical to report a mastectomy for mastoiditis/middle ear infection cases. Index coding can easily cause this combination to occur. The presence of the procedure codes (85.4x) without a related diagnosis code would clearly be in error.

V0316 Exclusive check (if match, error) - P015

Procedure Table 3001	85.41	Unilateral simple mastectomy
	85.42	Bilateral simple mastectomy
	85.43	Unilateral extended simple mastectomy
	85.44	Bilateral extended simple mastectomy
	85.45	Unilateral radical mastectomy
	85.46	Bilateral radical mastectomy
	85.47	Unilateral extended radical mastectomy
	85.48	Bilateral extended radical mastectomy
Relational Table 3003	383.00	Acute mastoiditis
	383.01	Subperiosteal abscess of mastoid
	383.1	Chronic mastoiditis
	383.20	Petrositis, unspecified
	383.21	Acute petrositis
	383.22	Chronic petrositis
	383.30	Postmastoidectomy complication, unspecified
	383.31	Mucosal cyst of postmastoidectomy cavity
	383.32	Recurrent cholesteatoma of postmastoidectomy cavity
	383.33	Granulations of postmastoidectomy cavity
	383.81	Postauricular fistula
	383.89	Other disorders of mastoid
	383.9	Unspecified mastoiditis
	384.00	Acute myringitis, unspecified
	384.01	Bullous myringitis
	384.09	Other disorders of tympanic membrane
	384.1	Chronic myringitis without mention of otitis media
	384.20	Perforation of tympanic membrane, unspecified
	384.21	Central perforation of tympanic membrane
	384.22	Attic perforation of tympanic membrane
	384.23	Other marginal perforation of tympanic membrane
	384.24	Multiple perforations of tympanic membrane
	384.25	Total perforation of tympanic membrane
	384.81	Atrophic flaccid tympanic membrane
	384.82	Atrophic nonflaccid tympanic membrane
	384.9	Unspecified disorder of tympanic membrane

V0316 **MASTECTOMY - ILLOGICAL FOR USE WITH DIAGNOSIS OF MASTOIDITIS AND MIDDLE EAR INFECTIONS** - CONTINUED
(see guideline on page 424)

V0316 Exclusive check (if match, error) - P015 - Continued

Relational Table 3003	385.00	Tympanosclerosis, unspecified as to involvement
	385.01	Tympanosclerosis involving tympanic membrane only
	385.02	Tympanosclerosis involving tympanic membrane and ear ossicles
	385.03	Tympanosclerosis involving tympanic membrane, ear ossicles, and middle ear
	385.09	Tympanosclerosis involving other combination of structures
	385.10	Adhesive middle ear disease, unspecified as to involvement
	385.11	Adhesions of drum head to incus
	385.12	Adhesions of drum head to stapes
	385.13	Adhesions of drum head to promontorium
	385.19	Other adhesions and combinations
	385.21	Impaired mobility of malleus
	385.22	Impaired mobility of other ear ossicles
	385.23	Discontinuity or dislocation of ear ossicles
	385.24	Partial loss or necrosis of ear ossicles
	385.30	Cholesteatoma, unspecified
	385.31	Cholesteatoma, attic
	385.32	Cholesteatoma, middle ear
	385.33	Cholesteatoma, middle ear and mastoid
	385.35	Diffuse cholesteatosis
	385.82	Cholesterin granuloma
	385.83	Retained foreign body of middle ear
	385.89	Other disorders of middle ear and mastoid
	385.9	Unspecified disorder of middle ear and mastoid

References: ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 57; 1991, page 61.

~~V0317 RADIUM IMPLANT PROCEDURES NEED MALIGNANCY DIAGNOSIS CODES~~ -
effective change as of 10/1/96

Guideline: When the purpose of a hospital admission is for the treatment of a malignancy by implantation or insertion of radioactive elements, the principal diagnosis is the neoplastic condition (malignancy) being treated with the radioactive element. Admissions for radium implants should not be coded to the V58 series. The code for malignancy should be assigned as the principal diagnosis in such cases. Radioactive implants should not be confused with oral radiotherapy treatments.

V0317	Exclusive check (if match, error) - P016	
Procedure Table 3001	92.27	Implantation or insertion of radioactive elements
Relational Table 3003	V58.0	Radiotherapy
	V58.1	Chemotherapy

References: Coding Clinic for ICD-9-CM, AHA, lst Quarter 1988, pages 4-5; 2nd Quarter 1990, page 8; 3rd Quarter 1992, pages 5-7; 3rd Quarter 1994, page 11.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 271; 1991, page 300; 1994, pages 320-321.

New change: Coding Clinic for ICD-9-CM, AHA, 3rd Quarter 1997, page 16.

V0318 DETOX, REHAB, OR BOTH PROCEDURES WITHOUT DIAGNOSIS OF ALCOHOLISM

Guideline: Certain procedures are performed only when a specific diagnosis is present. When a patient is admitted for the purpose of detoxification or rehabilitation or both, a code for the dependence or abuse should be reported. See sequencing guidelines for principal diagnosis on substance dependence and abuse in Coding Clinic, 2nd Quarter 1991, page 12. It is illogical to report rehab or detox without a diagnosis for alcohol dependence or abuse.

Other mental disorders, such as alcohol withdrawal syndrome, due to alcohol dependence or abuse are classified to the 291 series. A code should also be assigned for the dependence or abuse.

V0318 Inclusive check (if no match, error) - I005

Procedure Table 3001	94.61	Alcohol rehabilitation
	94.62	Alcohol detoxification
	94.63	Alcohol rehabilitation and detoxification
Relational Table 3003	648.3x	Pregnancy with drug dependence
	648.4x	Pregnancy with mental disorder
	655.5x	Suspected damage to fetus from drugs
	303.0x	Acute alcoholic intoxication
	303.9x	Other/unspecified alcohol dependence
	305.0x	Alcohol abuse

References: Coding Clinic for ICD-9-CM, AHA, 4th Quarter 1988, page 8; 2nd Quarter 1991, pages 12-13.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1991, pages 126-128; 1996, pages 117-121.

V0319 DETOX, REHAB, OR BOTH PROCEDURES WITHOUT DIAGNOSIS OF DRUG

Guideline: Certain procedures are performed only when a specific diagnosis is present. When a patient is admitted for the purpose of detoxification or rehabilitation or both, a code for the dependence or abuse should be reported. See sequencing guidelines for principal diagnosis on substance dependence and abuse in Coding Clinic, 2nd Quarter 1991, page 12. It is illogical to report rehab or detox without a diagnosis for drug dependence or abuse.

Other mental disorders, such as drug withdrawal syndrome, due to drug dependence or abuse are classified to the 292 series. A code should also be assigned for the dependence or abuse.

V0319 Inclusive check (if no match, error) - I006

Procedure Table 3001	94.64	Drug rehabilitation
	94.65	Drug detoxification
	94.66	Drug rehabilitation and detoxification
Relational Table 3003	648.3x	Pregnancy with drug dependence
	648.4x	Pregnancy with mental disorder
	655.5x	Suspected damage to fetus from drugs
	304.xx	Drug dependence
	305.1x	Tobacco use disorder
	305.xx	Drug abuse

References: Coding Clinic for ICD-9-CM, AHA, 4th Quarter 1988, page 8; .2nd Quarter 1991, pages 12-13.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1991, pages 126-128; 1996, pages 117-121.

V0320 DETOX, REHAB, OR BOTH PROCEDURES WITHOUT DIAGNOSIS OF COMBINED ALCOHOL AND DRUG

Guideline: Certain procedures are performed only when a specific diagnosis is present. When a patient is admitted for the purpose of detoxification or rehabilitation or both, a code for the dependence or abuse should be reported. See sequencing guidelines for principal diagnosis on substance dependence and abuse in Coding Clinic, 2nd Quarter 1991, page 12. It is illogical to report rehab or detox without a diagnosis for combined alcohol and drug dependence or abuse.

Other mental disorders, such as alcohol or drug withdrawal syndrome, due to alcohol or drug dependence or abuse are classified to the 291-292 series. A code should also be assigned for the dependence or abuse.

V0320 Inclusive check (if no match, error) - I007

Procedure Table 3001	94.67	Combined alcohol and drug rehabilitation
	94.68	Combined alcohol and drug detoxification
	94.69	Combined alcohol and drug rehabilitation and detoxification
Relational Table 3003	648.3x	Pregnancy with drug dependence
	648.4x	Pregnancy with mental disorder
	655.5x	Suspected damage to fetus from drugs
	303.0x	Acute alcoholic intoxication
	303.9x	Other/unspecified alcohol dependence
	304.xx	Drug dependence
	305.0x	Alcohol abuse
	305.1x	Tobacco use disorder
	305.2x	Drug abuse

References: Coding Clinic for ICD-9-CM, AHA, 4th Quarter 1988, page 8, 2nd Quarter 1991, pages 12-13.

ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1991, pages 126-128, 1996, pages 117-121.

V0321 DELIVERY FOR ANTEPARTUM CONDITION (BEFORE DELIVERY) OR POSTPARTUM CONDITION (AFTER DELIVERY)

Guideline: Certain procedures are performed only when a specific diagnosis is present. It is illogical to report delivery procedures for obstetrical diagnosis that indicate no delivery occurred this episode. Obstetrical conditions with fifth digits 3 and 4 are used only when delivery does not occur during the current episode.

x3 antepartum condition or complication (no delivery this episode, patient is still pregnant)

x4 postpartum condition or complication (no delivery this episode, delivery completed previously and patient is no longer pregnant)

The presence of delivery procedure codes with the non-delivery obstetrical conditions would clearly be in error.

V0321 Exclusive Check (if match, error) - P022

Procedure Table 3001	72.0	Low forceps operation
	72.1	Low forceps operation with episiotomy
	72.21	Mid forceps operation with episiotomy
	72.29	Other mid forceps operation
	72.4	Forceps rotation of fetal head
	72.51	Partial breech extraction with forceps to aftercoming head
	72.52	Other partial breech extraction
	72.54	Other total breech extraction
	72.6	Forceps application to aftercoming head
	72.71	Vacuum extraction with episiotomy
	72.79	Other vacuum extraction
	72.8	Other specified instrumental delivery
	72.9	Unspecified instrumental delivery
	~~73.21~~	~~Internal and combined version without extraction~~ *(this was removed for records with discharge date beginning 07-01-94)*
	73.22	Internal and combined version with extraction
	73.51	Manual rotation of fetal head
	73.59	Other manually assisted delivery
	73.6	Episiotomy
	74.0	Classical cesarean section
	74.1	Low cervical cesarean section
	74.2	Extraperitoneal cesarean section
	74.4	Cesarean section of other specified type
	74.99	Other cesarean section of unspecified type

V0321 **DELIVERY FOR ANTEPARTUM CONDITION (BEFORE DELIVERY) OR POSTPARTUM CONDITION (AFTER DELIVERY)** Continued
(see guideline on page 430)

V0321 Exclusive Check (if match, error) - P022 - Continued

Relational Table 3003	640.0 - 648.9 with 5th digit "**3**" or "**4**"	Complications relating to pregnancy
	651.0 - 659.9 with 5th digit "**3**" or "**4**"	Other indications for care in pregnancy, care, and delivery
	660.0 - 669.9 with 5th digit "**3**" or "**4**"	Complications occurring in the course of labor and delivery
	670.0 - 676.9 with 5th digit "**3**" or "**4**"	Complications of the puerperium

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References: ICD-9-CM Codebook, Tabular List, Complications Mainly Related to Pregnancy (640-648), see Definitions for Each Fifth Digit

ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, Complications of Pregnancy, Childbirth, and the Puerperium, page 179.

ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1991, Complications of Pregnancy, Childbirth, and the Puerperium, page 206.

Steps to Coding with ICD-9-CM Module II, CHIA, 1991, page 157.

V0322 COMPLICATED DELIVERY PROCEDURE FOR DIAGNOSIS OF "NORMAL PREGNANCY"

Guideline: Obstetrical procedures that can be associated with diagnosis code 650 are episiotomy and episiorrhaphy, amniotomy (artificial rupture of the membranes), unassisted delivery, administration of analgesics and/or anesthesia, and fetal monitoring. Any other obstetrical procedures (72.x, 73.4, 74.x) cannot be used correctly with a normal delivery diagnosis code 650.

Procedure code 73.4, Medical induction of labor, cannot be used correctly with a normal delivery diagnosis code 650. Code 73.4 should only be used to start the labor if the patient is not in labor. Code 73.4 should not be used if the patient is already in labor. If everything appears normal but the physician medically induces labor, the physician should be consulted as to why there is medical induction (failure to progress?, post-term?, or premature rupture of membranes?). A complication of delivery diagnosis code should then be assigned rather than normal delivery diagnosis code 650. Exception: If the patient truly had a normal pregnancy (650) and induction to "begin" labor (73.4), leave the data as is.

V0322 Exclusive check (if match, error) - P023

Procedure Table 3001	72.0	Low forceps operation
	72.1	Low forceps operation with episiotomy
	72.21	Mid forceps operation with episiotomy
	72.29	Other mid forceps operation
	72.4	Forceps rotation of fetal head
	72.51	Partial breech extraction with forceps to aftercoming head
	72.52	Other partial breech extraction
	72.54	Other total breech extraction
	72.6	Forceps application to aftercoming head
	72.71	Vacuum extraction with episiotomy
	72.79	Other vacuum extraction
	72.8	Other specified instrumental delivery
	72.9	Unspecified instrumental delivery
	73.4	Medical induction of labor *(prior to active labor)*
	74.0	Classical cesarean section
	74.1	Low cervical cesarean section
	74.2	Extraperitoneal cesarean section
	74.3	Removal of extratubal ectopic pregnancy
	74.4	Cesarean section of other specified type
	74.91	Hysterotomy to terminate pregnancy
	74.99	Other cesarean section of unspecified type
Relational Table 3003	650	Delivery in a completely normal case

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References: ICD-9-CM Codebook, Tabular List, Coding Instruction Note under Diagnosis Code 650.
ICD-9-CM Coding Handbook With Answers, AHA, Faye Brown, RRA, 1989, page 182; 1991, page 209
Central Office on ICD-9-CM, Response to OSHPD's Letter #195.81 dated 03-23-92.

STOP!!!
NEXT V EDIT IS V0401